

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001484

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 310

FILED FEB 6 1963

VS 300 Rev. 4/59	DATE AMENDED	1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>
1		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>	c. CITY OR TOWN <u>KANSAS CITY</u>
2 3548		Length of stay in 1b <u>68 yrs</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3		c. FULL NAME OF (If NOT in hospital, give location) <u>3418 Wabash</u>	d. STREET ADDRESS (If outside, give location) <u>3418 Wabash</u>
4 2		3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>FRANKLIN</u> Last <u>CARGYLE</u>	4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>63</u>
5 1		5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>
6		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-1894</u>
7 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	9. AGE (last birthday) <u>68 yrs.</u>
8 0		10b. KIND OF BUSINESS OR INDUSTRY	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
9 593X		11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
10		13a. FATHER'S NAME <u>Jim Cargyle</u>	14. NAME OF HUSBAND OR WIFE <u>Lorraine Cargyle</u>
11		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	17. INFORMANT <u>Lorraine Cargyle</u>
12 90-2		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>
13		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Nephritis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>10 years</u>
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
		20c. TIME OF INJURY Hour <u>3:15</u> a.m. p.m. Month, Day, Year	
		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
		20f. CITY, TOWN, OR LOCATION <u>Ft. Leavenworth, Kansas</u>	COUNTY <u>JACKSON</u> STATE <u>MISSOURI</u>
		21. I attended the deceased from <u>Aug 53</u> to <u>Jan 16, 1963</u> and last saw him alive on <u>Jan 16, 1963</u> Death occurred at: <u>3:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
		22a. SIGNATURE (Degree or title) <u>Carl T. Moore D.O.</u>	22b. ADDRESS <u>6425 E 37th K.C. 25 Mo</u>
		22c. DATE SIGNED <u>1-17-63</u>	
		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-21-63</u>
		23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ft. Leavenworth, Kansas</u>
		24. FUNERAL DIRECTOR <u>WATKINS BROS. FUNERAL HOME</u>	25. DATE RECD. BY LOCAL REG. <u>1-18-63</u>
		26. REGISTRAR'S SIGNATURE <u>Keith Long</u>	

USE BLACK INK
OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Carl T. Moore

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bruce R. Watkins

Licensed Embalmer No. 4500

P. O. Address 1800 1st St. S.E.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.